

BENEFIT CATEGORY	STATE OF IDAHO CURRENT TRADITIONAL PLAN	BLUE CROSS OF IDAHO TRUE BLUE (HMO)	REGENCE BLUE SHIELD MEDADVANTAGE + Rx (PPO)	BLUE CROSS CLASSIC BLUE PLAN 'J'	REGENCE BLUE SHIELD SENIOR SELECTION PLAN 'F'
DEDUCTIBLES INDIVIDUAL FAMILY	\$350 \$1,050	No Deductible No Deductible	No Deductible No Deductible	No Deductible No Deductible	No Deductible No Deductible
MAJOR MEDICAL OUT-OF-POCKET LIMITS INDIVIDUAL FAMILY	\$4,300 \$8,600	No Limit N/A	In-Network - \$1,000 Out-of-Network - \$2,000 N/A	No Limit N/A	No Limit N/A
LIFETIME BENEFIT LIMIT	\$1,000,000	None	None	None	None
INPATIENT HOSPITAL	Participating Provider Member pays 20% of the allowed amount after the deductible is met - Includes physical rehab limit of \$15,000 per insured per benefit period	In-Network – Member pays \$0 copay Out-of-Network - No coverage unless plan prior authorizes, except in an emergency. - Includes substance abuse & rehab with no limit - Unlimited days per stay	In-Network - \$100 copay for days 1-3; Out-of-Network - Member pays \$200 copay for days 1-5; - 100% coverage for Medicare covered services following 3 days in-network or 5 days out-of-network. - Includes substance abuse & rehab with no limit - Unlimited days per stay. - Covered under In-Network benefit if admitted due to emergency.	Plan pays Medicare Part A deductible and coinsurance in full. Member pays \$0. Additional 365 lifetime reserve days.	Plan pays Medicare Part A deductible and coinsurance in full. Member pays \$0. Additional 365 lifetime reserve days.
SKILLED NURSING FACILITY	Participating & Non-participating Member pays 20% of allowable after the deductible is met - 30 days covered per benefit period	In-Network Member pays Days 1-7: \$0 copay per day Days 8-19: \$25 copay per day Days 20-100: \$0 copay per day; \$300 out-of-pocket limit every stay Out-of-Network No coverage unless plan prior authorizes - 100 days covered per benefit period	In-Network Member pays \$0 copay for first 100 days. Out-of-Network Days 1-25: \$0 copay per day Days 26-100: \$25 copay per day - 100 days covered per benefit period	Plan pays Medicare Part A copayments in full. Member pays \$0. - 100 days covered per benefit period.	Plan pays Medicare Part A copayments in full. Member pays \$0. - 100 days covered per benefit period.

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HOME HEALTH CARE	<p>Participating & Non-participating Member pays 20% of the allowed amount after the deductible is met</p> <p>Limited to \$5,000 per insured per benefit period</p>	<p>In-Network Member pays \$0 copay Out-of-Network No coverage unless plan prior authorizes</p> <p>No limit</p>	<p>In-Network Member pays \$0 copay Out-of-Network Member pays 20%</p> <p>No limit</p>	<p>Plan pays Medicare Part A and Part B copayments and coinsurance in full. Member pays \$0.</p> <p>Provides additional 8 weeks of at home help after skilled care no longer needed up to \$40 per visit and \$1,600 each year.</p>	<p>Plan pays Medicare Part A and Part B copayments and coinsurance in full. Member pays \$0.</p>
HOSPICE	<p>Participating Providers Only Member pays nothing Deductible does not apply</p> <p>\$10,000 lifetime benefit limit per Insured</p>	<p>In-Network Must get care from a Medicare-certified hospice Out-of-Network Must get care from a Medicare-certified hospice</p>	<p>In-Network Must get care from a Medicare-certified hospice Out-of-Network Must get care from a Medicare-certified hospice</p>	<p>Benefits must be provided by a Medicare certified hospice provider. Minimal copayments apply.</p>	<p>Benefits must be provided by a Medicare certified hospice provider. Minimal copayments apply.</p>
DOCTOR OFFICE VISITS	<p>Participating & Non-Participating Member pays 20% of the allowed amount after the deductible is met.</p>	<p>In-Network Member pays a \$10 copay for each primary care doctor visit; Member pays a \$20 copay for each specialist visit Out-of-Network No coverage unless plan prior authorizes</p>	<p>In-Network Member pays a \$5 copay for each primary care doctor or specialist visit Out-of-Network Member pays a \$20 copay for each visit.</p>	<p>Plan pays Medicare Part B annual deductible, coinsurance and Medicare approved excess charges. Member pays \$0</p>	<p>Plan pays Medicare Part B annual deductible, coinsurance and Medicare approved excess charges. Member pays \$0</p>
OUTPATIENT SERVICES & SURGERY	<p>Participating & Non-Participating Member pays 20% of the allowed amount after the deductible is met</p>	<p>In-Network Member pays \$0 copay Out-of-Network No coverage unless plan prior authorizes</p>	<p>In-Network Member pays \$0 copay Out-of-Network Member pays \$100 copay</p>	<p>Plan pays Medicare Part B annual deductible, coinsurance and Medicare approved excess charges. Member pays \$0.</p>	

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AMBULANCE	Participating & Non-Participating Member pays 20% of the allowed amount after the deductible is met	In- and Out-of-Network Member pays \$0 copay	In- and Out-of-Network Member pays \$50 copay	Plan pays Medicare Part B annual deductible and coinsurance. Member pays \$0.	
EMERGENCY	Participating & Non-Participating Member pays 20% of the allowed amount after the deductible is met	In- and Out-of-Network Member pays a \$50 copay for ER visits Worldwide coverage In- and Out-of-Network If admitted to the hospital within 3-day(s) for the same condition, copay is waived.	In- and Out-of-Network Member pays a \$50 copay Worldwide coverage In- and Out-of-Network If admitted to the hospital within 48 hours, copay is waived.	Plan pays Medicare Part B annual deductible, coinsurance and Medicare approved excess charges. Member pays \$0	
DURABLE MEDICAL EQUIPMENT	In-Network & Out-of-Network Member pays 20% of the allowed amount after the deductible is met	In-Network Member pays \$0 copay Out-of-Network No coverage unless plan prior authorizes	In-Network Member pays 10% Out-of-Network Member pays 20%	Plan pays Medicare Part B annual deductible and coinsurance. Member pays \$0 for the Medicare approved charges.	
DIAGNOSTIC TESTS, X-RAYS AND LAB SERVICES	Participating & Non-participating Member pays 20% of the allowed amount after the deductible is met	In-Network Member pays \$0 copay Out-of-Network No coverage unless plan prior authorizes	In- and Out-of-Network Member pays \$0 copay	Plan pays Medicare Part B annual deductible, coinsurance and excess charges. Member pays \$0.	
PRESCRIPTION DRUGS	This plan <u>DOES NOT</u> use a formulary \$0 Deductible Retail Pharmacy	This plan uses a formulary In-Network \$0 Deductible Initial Coverage Member pays the following until total drug costs reach \$2,510 Retail Pharmacy	This plan uses a formulary In-Network \$275 Deductible Initial Coverage Member pays the following until total drug costs reach \$2,510 Retail Pharmacy	There is no coverage for Prescriptions in this plan. Member must purchase separate Medicare Part D plan for prescription coverage	

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PRESCRIPTION DRUGS (CONTINUED)	<p>Tier 1 - Generic - \$10 copay 30-day supply - \$20 copay 90-day supply Tier 2: Brand –no Generic - \$18 copay 30-day supply - \$36 copay 90-day supply Tier 3: Brand with Generic - \$40 + difference between Brand and Generic</p> <p>NO Coverage Gap</p>	<p>Tier 1 – Generic - \$6 copay for each 30-day supply Tier 2 – Preferred Brand - \$20 copay for each 30-day supply Tier 3 – Non Preferred Brand -\$35 copay for each 30-day supply Tier 4 – Injectables - 25% coinsurance 30-day supply Tier 5 – Specialty Drugs - 25% coinsurance 30-day supply</p> <p>Coverage Gap After total yearly drug costs reach \$2,510, plan covers only select drugs through the Gap. Member pays the following:</p> <p>Retail Pharmacy Tier 1 – Generic - \$6 copay per 30-day supply - Member pays 100% until out-of-pocket drug costs reach \$4,050 for all other medications.</p> <p>Catastrophic Coverage After yearly out-of-pocket drug costs reach \$4,050 member pays the greater of: - \$2.25 copay for generic (including brand drugs treated as generic) & \$5.60 copay for all other drugs, or 5% coinsurance</p> <p>Mail Order Available</p>	<p>Tier 1 – Generic - \$5 copay for each 30 day supply Tier 2 – Preferred Brand -\$14 copay for each 30 day supply Tier 3 – Non Preferred Brand -\$30 copay for each 30 day supply Tier 4 – Specialty drugs -25% coinsurance 30 day supply Tier 5 – Injectables - 25% coinsurance 30 day supply</p> <p>Coverage Gap Member pays 100% of discounted drug costs until he has spent \$4,050</p> <p>Catastrophic Coverage After yearly out-of-pocket drug costs reach \$4,050 member pays the greater of -\$2.25 or \$5.60 copay or 5% coinsurance, depending upon the tier</p> <p>Mail Order Available</p>	<p style="text-align: center;"><u>MEDICARE PART D</u></p> <p>Deductible = \$ 0 to \$275 per year</p> <p>Copayment/Coinsurance = Amounts vary depending on Plan design until member coinsurance/copayments and the amount the Part D plan have paid equal \$2,510 (including deductible)</p> <p>Coverage Gap = When the member and the plan have paid \$2,510 (including deductible amounts), he pays 100% of the cost of medications until he has spent \$4,050 out-of-pocket. (This includes deductible and coinsurance/copayment amounts, and what he’s paid while in the coverage gap.)</p> <p>Catastrophic Coverage = Once the member has paid \$4,050, the coverage gap ends and he pays either a copayment of \$2.25 for generic and \$5.60 for non-generic medications, OR coinsurance of 5% for all medications until the end of the year.</p>	
	<p>NO Mail Order Benefit</p>				

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VISION	Not a benefit	Some Vision Benefits Available	Some Vision Benefits Available	For diagnosis and treatment of diseases and conditions of the eye the plan pays Medicare Part B annual deductible, coinsurance and excess charges. Member pays \$0. \$0 copay for - one pair of eyeglasses or contact lenses after each cataract surgery Some benefits for eye exams, and hardware.	For diagnosis and treatment of diseases and conditions of the eye the plan pays Medicare Part B annual deductible, coinsurance and excess charges. Member pays \$0. \$0 copay for - one pair of eyeglasses or contact lenses after each cataract surgery
DENTAL	Only for services related to an accident; member pays 20% after deductible	Some Dental Benefits Available	Some Dental Benefits Available	Optional Dental (\$15.10/mo)	Some Preventive Benefits Available
HEARING SERVICES	Not a benefit	Some Hearing Benefits Provided	Some Hearing Benefits Provided	Not a benefit	Not a benefit
SERVICE AREAS	Statewide	Available in the following Idaho counties: Ada, Bannock, Benewah, Boise, Bonner, Bonneville, Boundary Canyon, Caribou, Cassia, Gem, Jefferson, Kootenai, Latah, Madison, Minidoka, Nez Perce, Oneida, Owyhee, Payette, Power, Shoshone, Twin Falls, Washington	Available in the following Idaho counties: Ada, Bannock, Bingham, Boise, Bonner, Bonneville, Canyon, Elmore, Jefferson, Kootenai, Latah, Madison, Minidoka, Nez Perce, Owyhee, Payette, Power, and Shoshone. Also, Asotin County in Washington. Not available to those who have End Stage Renal Disease (ESRD)	Any Medicare participating provider Nationwide.	Any Medicare participating provider Nationwide.

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MONTHLY PREMIUM 2008	\$274.00	\$ 95.00- \$130.00	\$120.00	\$152.00 – \$175.00 (Rated for average retiree age 72, Smoker & Non- Smoker)	\$174.00 - \$206.00 (Rated for average retiree age 72, Smoker & Non-Smoker)
MEDICARE PART D 2008 AVERAGE COST	N/A	N/A	N/A	\$30.00	\$30.00
PREMIUM IMPACT –VS- STATE PLAN *	N/A	Savings of \$179 - \$144.00	Savings of \$154.00	Savings of \$92 - \$69	Savings of \$70 - \$38

* These savings are based on a premium – to – premium comparison only and do not include additional savings retirees may experience in deductible, co-insurance, dental and vision coverage.